

emailed validation
letter 10/1/10

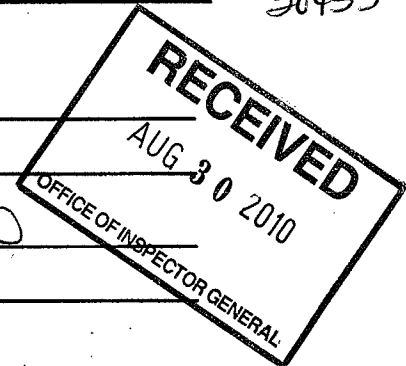
**Application for License to
Operate a Long-term Care Facility**

For Office Use Only
Received 8-30-10
Amount \$300-

Ch# 30455

I. IDENTIFICATION

Name Shenwell Health Care
Address 805 Princeton St
City/County/Zip Providence Ky 40480
Telephone number 270 467 5472
Administrator Billie Cole RN
Date facility operation began at current address 1960
Date facility began operation under current owner 1974



II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u>20</u>	<u>20</u>
Nursing Home	<u>20</u>	<u>20</u>
Nursing Facility	<u>2</u>	<u>2</u>
Intermediate Care	<u>2</u>	<u>2</u>
ICF/MR	<u> </u>	<u> </u>
Personal Care	<u> </u>	<u> </u>

II. CONTROL (check one in each column)

State	Profit <input checked="" type="checkbox"/>	Individual
County	Nonprofit	Partnership <input checked="" type="checkbox"/>
City		Corporation
Private <input checked="" type="checkbox"/>		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Wayne: Billie Cole 121 E. Main St. Providence Ky
Tommy & Beinta Chander 218 Benjamin T. Enloe Providence Ky

(OVER)

9/30

If facility owned or leased by a corporation, complete the following:

Name of corporation _____

Address of corporation _____

President or Chairman _____

Vice President _____

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent

Management Company

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Shirley Kanove
Signature of authorized representative

RNDON
Title

8/27/10
Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)